

COVID-19 risk triage: Engaging residents in telephonic screening

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1 | WHAT PROBLEMS WERE ADDRESSED?

In our internal medicine clinic, calls for concerns related to the coronavirus disease 2019 (COVID-19) outpaced traditional nursing triage protocols, whereas in-person visits and educational obligations for residents declined. Similar to many primary care practices during the COVID-19 pandemic, we needed to effectively address both patient care and residents' educational needs.

2 | WHAT WAS TRIED?

In response to the demand to screen symptomatic patients, we created a risk assessment triage process that utilised residents' clinical reasoning skills without direct exposure to high-risk patients. Our academic internal medicine practice includes both resident and faculty member clinics, with residents rotating through clinic every 2 weeks. All patients calling the practice with respiratory symptoms or fever were referred to a shared message pool within our electronic medical record. Two residents per half-day verbally telephoned these patients to assess their risk factors for COVID-19 and made management recommendations (including the need for testing). A designated, rotating faculty preceptor was available to discuss challenging cases and review documentation.

3 | WHAT LESSONS WERE LEARNED?

To date, residents have responded efficiently to patient calls, allowing us to promptly address patient concerns and triage unstable patients. Additionally, residents have appreciated participating in the care of patients at risk of COVID-19 when learning about evidence-based management strategies.

Daily call volume for screening and the need for follow-up calls to monitor symptom progression rose with community spread of COVID-19. In response, we designated additional rotating residents

to call patients every 24 to 72 hours depending on their risk of decompensation. We additionally recruited fellows and high-risk or quarantined faculty members to assist with screening. To optimise daily patient hand-overs, we selected faculty 'list masters,' who distributed patients daily to the designated follow-up residents. Given the rapidly changing recommendations, we provided a remote orientation biweekly for new providers and maintained guidelines, call scripts and documentation templates on a shared drive.

From an educational standpoint, involvement in the triage and follow-up process fulfils multiple residency competencies and connects residents to frontline COVID-19 pandemic efforts. Residents exercised clinical reasoning and judgement, justifying their management decisions in discussions and documentation. They learned to assess and integrate rapidly changing guidelines and evidence. We additionally started virtual ambulatory case conferences for peer education about nuanced cases, extending the educational impact beyond the residents performing screening. Residents practised individualised patient education and addressed social determinants of our vulnerable populations. Involvement in the follow-up process taught residents about population health concepts, such as limiting transmission and preventing infection clusters, with residents at the frontlines to recruit patients for contact tracing research efforts.

We anticipate frequent modification to this process and the need for flexibility in response to evolving patient care requirements and resources. Given the rapid implementation of this intervention, we have been limited in outcome metrics to the timely response to large numbers of patient concerns. We aim to examine patient and resident satisfaction with the programme, in addition to patient and educational outcomes being tracked by the institution. Overall, we believe that this system has successfully balanced patient care needs with education for our residents.

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